MISSOURI DEPARTMENT OF MENTAL HEALTH

Keith Schafer, Department Director

DEPARTMENT OPERATING REGULATION NUMBER
DOR 8.050

CHAPTER	SUBCHAPTER	EFFECTIVE DATE	NUMBER OF PAGES	PAGE NUMBER
Regulatory Compliance	HIPAA Regulation	6/30/15	3	1 of 3

SUBJECT	AUTHORITY	History
Policy and Procedures for Obtaining Authorization for the Disclosure of Protected Health Information	Section 630.050 RSMo	See Below

PERSON RESPONSIBLE	SUNSET DATE
General Counsel	7/1/18

POLICY: It is the policy of the Department of Mental Health (DMH) to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information and confidentiality. It is also the policy of DMH to provide for the consumer's voluntary authorization for use or disclosure of his or her protected health information (PHI) as set out in 45 CFR Sections 164.508; 164.510; and 164.512. Whether PHI may be used or disclosed is subject to the review of the Health Information Management Department (HIMD) Director, Client Information Center, or his/her designee.

APPLIES: DMH, its facilities and workforce.

(1) DEFINITIONS:

(A) Consumer: Any individual who has received or is receiving services from the Department of Mental Health..

(B) Disclosure: The release, transfer, provision of access to, or divulging in any other manner of information outside the entity which holds the information. This includes disclosures to or by business associates of the covered entity.

(C) Psychotherapy notes: Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the consumer's medical record. Such notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress notes to date.

(D) Protected Health Information (PHI): Individually identifiable health Information that is transmitted or maintained in any form or medium, by a covered entity, health plan or clearinghouse as defined under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 160 and 164.

(2)PROCEDURE:

(A) A facility shall not use or disclose PHI without a valid "Authorization for Disclosure of Consumer Medical/Health Information" form completed by the consumer, or personal representative, with limited exceptions as listed in subsection (E).

(B) The Facility Health Information Management Director (HIMD) shall obtain written information regarding the identity of the requestor, the date of the request,

the nature and purpose of the request and any authority that the requestor has to request such information, consistent with DOR 8.070 on Verification Procedures. If other staff receives a completed authorization form for the release of PHI, they shall direct it to the facility HIMD or Client Information Center representative for review.

(C) Disclosures of PHI shall be limited to the minimum amount of information necessary to meet the purpose of the use or disclosure.

1. Exceptions to the minimum necessary requirement are as follows:
   a. When the consumer authorizes the disclosure;
   b. Disclosures required by law.

(D) The facility must obtain an authorization for any use or disclosure of psychotherapy notes except:

a. To carry out treatment, payment or health care operations;

b. For the facility to use in defending itself in litigation or other proceedings brought by the consumer.

(E) PHI may only be disclosed without authorization in the following situations:

1. To a public health authority (i.e. required reporting to the Missouri Department of Health and Senior Services);
2. To report child abuse/neglect situations, and other situations involving abuse, neglect or domestic violence (if disclosure is allowed by law);
3. To the Food and Drug Administration;
4. To a health oversight agency;
5. To judicial or administrative proceedings (a subpoena from a court is not enough);
6. To law enforcement (but only in certain circumstances; including when they present a grand jury subpoena; information concerning forensic clients; to locate a missing person, suspect, or fugitive; or at the discretion of the head of the facility when the information is requested to assist law enforcement in their investigation [see Section 630.140, Revised Statutes of Missouri]);
7. To avert a serious threat to health or safety [see also DMH Department Operating Regulation 4.410, concerning the duty to warn requirements.
8. Governmental functions (such as national security; veterans information);
9. To other agencies administering public benefits;
10. To medical examiners and coroners;
11. To funeral directors;
12. For organ donation purposes;
13. For some research purposes; or
14. As required by law.

(3) Any questions as to whether a use or disclosure is permitted or required by law shall be directed to the Facility HIMD, the Client Information Center representative, or the facility Privacy Officer or his/her designee.

(4) If it is the facility that requests that the consumer complete the authorization, the facility shall provide the consumer with a copy of the signed "Authorization for Disclosure of Consumer Medical/Health Information" form.

(5) LOCAL POLICIES: There shall be no facility policies pertaining to this topic. The Department Operating Regulation shall control.

(6) SANCTIONS: Any person found to have violated the requirements of this DOR shall be subject to the sanctions up to and including dismissal.

(7) REVIEW PROCESS: Information shall be collected from the facility Privacy Officers annually to monitor compliance and identify any issues with this DOR.

(8) ATTACHMENT: Authorization for Disclosure of Consumer Medical/Health Information form.

History: Original DOR effective date January 1, 2003. Final DOR effective June 1, 2003. Amendment effective July 1, 2006. On July 1, 2009, the sunset date was extended to July 1, 2012. Amendment effective June 25, 2012. Amendment effective June 30, 2015.

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)

☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)

☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)

to **(check all that apply)**

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)

☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)

☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

_____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☐ Eligibility Determination ☐ Assessment ☐ Aftercare

☐ Placement ☐ Transfer/Treatment ☐ Treatment Planning

☐ Continuity of Services/Care ☐ Conditional/Unconditional Release Hearing ☐ At Consumer's Request

☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)

☐ Other (specify) _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

☐ Discharge Summary ☐ Progress Notes ☐ Treatment Plan and/or Review

☐ Social Service Assessment ☐ Educational testing, IEP, transcript, and/or grading reports

☐ Medical/Psychiatric Assessment(s) ☐ Psychotherapy notes

☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.

☐ Other _____

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases or environmental conditions, and/or alcohol/drug abuse.

2. THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information: _____

   THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.

4. This authorization becomes effective on _____ . This authorization automatically expires on the following date, event or special condition _____ .

5. If I fail to specify an expiration date, this authorization will expire in one year.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.

7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE

I, _____ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.